		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045526

Facility Name: PRESIDENTIAL PAVILION

Address: 8001 S. WESTERN AVENUE (Number) CHICAGO (City) 60620 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-4465311

Date of Initial License for Current Owners: 10/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	218	Skilled (SNF)	218	79,570	1
2		Skilled Pediatric (SNF/PED)			2
3	110	Intermediate (ICF)	110	40,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	119,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	31,059	92	18,757	49,908	8
9	SNF/PED					9
10	ICF	68,690	309	46	69,045	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	99,749	401	18,803	118,953	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.36%

D. How many bed-hold days during this year were paid by Public Aid?
120 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 18,572

Medicare Intermediary BLUE CROSS - BLUE SHIELD

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	313,708	32,111	16,123	361,942		361,942		361,942			1
2	Food Purchase		403,709		403,709	(23,214)	380,495	(3,635)	376,860			2
3	Housekeeping	322,018	52,505		374,523		374,523		374,523			3
4	Laundry	117,132	22,409	6,432	145,973		145,973		145,973			4
5	Heat and Other Utilities			242,640	242,640		242,640	937	243,577			5
6	Maintenance	106,538	57,936	126,021	290,495		290,495	7,587	298,082			6
7	Other (specify):* Security	152,998		36,900	189,898		189,898	69	189,967			7
8	**TOTAL General Services**	1,012,394	568,670	428,116	2,009,180	(23,214)	1,985,966	4,958	1,990,924			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,360,968	91,412	62,176	3,514,556		3,514,556		3,514,556			10
10a	Therapy	133,424		24,924	158,348		158,348		158,348			10a
11	Activities	160,444	43,341	3,360	207,145		207,145		207,145			11
12	Social Services	175,897		4,374	180,271		180,271		180,271			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,830,733	134,753	100,834	4,066,320		4,066,320		4,066,320			16
	C. General Administration											
17	Administrative	177,714		905,000	1,082,714		1,082,714	(787,472)	295,242			17
18	Directors Fees											18
19	Professional Services			116,550	116,550		116,550	15,889	132,439			19
20	Dues, Fees, Subscriptions & Promotions			29,527	29,527		29,527	(5,342)	24,185			20
21	Clerical & General Office Expenses	257,418	28,876	143,164	429,458		429,458	(136,130)	293,328			21
22	Employee Benefits & Payroll Taxes			808,722	808,722	23,214	831,936		831,936			22
23	Inservice Training & Education							66	66			23
24	Travel and Seminar			2,425	2,425		2,425		2,425			24
25	Other Admin. Staff Transportation			6,620	6,620		6,620	1,247	7,867			25
26	Insurance-Prop.Liab.Malpractice			185,906	185,906		185,906	1,658	187,564			26
27	Other (specify):*			195,741	195,741		195,741	(184,798)	10,943			27
28	**TOTAL General Administration**	435,132	28,876	2,393,655	2,857,663	23,214	2,880,877	(1,094,882)	1,785,995			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,278,259	732,299	2,922,605	8,933,163		8,933,163	(1,089,924)	7,843,239			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: PRESIDENTIAL PAVILION **#0045526** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	16,123	
	REPAIRS & MAINTENANCE		0	
			0	16,123
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		6,432	
			0	6,432
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		93,194	
	ELECTRICITY		109,150	
	WATER		40,296	
	CABLE TV - LOBBY		0	
			0	242,640
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,260	
	PAINTING & DECORATING		1,530	
	BUILDING REPAIRS		3,374	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		48,040	
	ELEVATOR MAINTENANCE & REPAIR		36,304	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		8,463	
	FIRE SERVICE		25,050	
			0	
			0	
			0	126,021
7	**OTHER**			
	SCAVENGER		22,060	
	SECURITY SERVICE		14,840	36,900
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	17,643	
	LABORATORY & XRAY EXPENSE		21,361	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	12,972	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	6,000	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		4,200	
			0	62,176
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		414	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	24,000	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	510	24,924
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,360	
			0	3,360
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	4,374	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	4,374
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PRESIDENTIAL PAVILION **#0045526** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	905,000	905,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	20,296	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	96,254	
			0	116,550
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,680	
	EMPLOYEE WANT ADS	XIX F	4,856	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	13,174	
	LICENSES & PERMITS	XIX F	3,062	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,705	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,050	29,527
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		135	
	EQUIPMENT REPAIR & MAINTENANCE		5,971	
	OUTSIDE CLERICAL SERVICES		30,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,289	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		26,109	
	MESSENGER SERVICE		0	
	Staff Development, Non deductable Patient Costs		79,660	143,164

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	393,914	
	UNEMPLOYMENT COMPENSATION	XIX D	58,641	
	WORKERS COMPENSATION INSURANCI	XIX D	156,753	
	HOSPITALIZATION INSURANCE	XIX D	139,898	
	EMPLOYEE BENEFITS - OTHER	XIX D	10,062	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	36,482	
	CHICAGO HEAD TAX	XIX D	12,972	808,722
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,425	
	TRAVEL	XIX G	0	
			0	
			0	2,425
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,620	6,620
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		185,906	185,906
27	**OTHER**			
	BAD DEBTS	VI 24	195,741	
			0	195,741

GRAND TOTAL COLUMN 3 OTHER 2,922,605

Facility Name & ID Number PRESIDENTIAL PAVILION #0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			158,259	158,259		158,259	(64,615)	93,644			30
31	Amortization of Pre-Op. & Org.			780	780		780		780			31
32	Interest			77,937	77,937		77,937	3,887	81,824			32
33	Real Estate Taxes			339,620	339,620		339,620	4,834	344,454			33
34	Rent-Facility & Grounds			1,555,650	1,555,650		1,555,650		1,555,650			34
35	Rent-Equipment & Vehicles			49,425	49,425		49,425	9,302	58,727			35
36	Other (specify):* IME RENT			25,584	25,584		25,584	(25,584)				36
37	**TOTAL Ownership**			2,207,255	2,207,255		2,207,255	(72,176)	2,135,079			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		379,713	574,902	954,615		954,615		954,615			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,580	179,580		179,580		179,580			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		379,713	754,482	1,134,195		1,134,195		1,134,195			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,278,259	1,112,012	5,884,342	12,274,613		12,274,613	(1,162,100)	11,112,513			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(67,596)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,635)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,289)	21		18
19	Entertainment		20		19
20	Contributions	(4,705)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(195,741)	27		24
25	Fund Raising, Advertising and Promotional	(1,680)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(531,509)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (806,155)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(355,945)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (355,945)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,162,100)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PRESIDENTIAL PAVILION

ID# 0045526

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,953	6	1
2	MARKETING SALARIES	(81,167)	21	2
3	BANK CHARGES	(135)	21	3
4	STAFF DEVELOPMENT	(78,338)	21	4
5	NON-DEDUCTIBLE PATIENT COSTS	(1,322)	21	5
6	PHILIP ESFORMES,INC MANAGEMENT FEES	(372,500)	17	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(531,509)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,635)	0	0	0	0	0	0	0	0	0	0	(3,635)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	937	0	0	0	0	0	0	0	937	5
6	Maintenance	1,953	0	4,137	1,497	0	0	0	0	0	0	0	7,587	6
7	Other (specify):*	0	0	69	0	0	0	0	0	0	0	0	69	7
8	**TOTAL General Services**	(1,682)	0	4,206	2,434	0	0	0	0	0	0	0	4,958	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(372,500)	(427,627)	12,655	0	0	0	0	0	0	0	0	(787,472)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	320	15,171	398	0	0	0	0	0	0	0	15,889	19
20	Fees, Subscriptions & Promotions	(6,385)	0	1,043	0	0	0	0	0	0	0	0	(5,342)	20
21	Clerical & General Office Expenses	(162,251)	13,262	12,670	189	0	0	0	0	0	0	0	(136,130)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	66	0	0	0	0	0	0	0	0	66	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	383	864	0	0	0	0	0	0	0	0	1,247	25
26	Insurance-Prop.Liab.Malpractice	0	297	1,172	189	0	0	0	0	0	0	0	1,658	26
27	Other (specify):*	(195,741)	4,227	6,716	0	0	0	0	0	0	0	0	(184,798)	27
28	**TOTAL General Administration**	(736,877)	(409,138)	50,357	776	0	0	0	0	0	0	0	(1,094,882)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(738,559)	(409,138)	54,563	3,210	0	0	0	0	0	0	0	(1,089,924)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(67,596)	0	460	2,521	0	0	0	0	0	0	0	(64,615)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	3,887	0	0	0	0	0	0	0	3,887	32
33	Real Estate Taxes	0	0	0	4,834	0	0	0	0	0	0	0	4,834	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,846	7,220	236	0	0	0	0	0	0	0	9,302	35
36	Other (specify):*	0	0	0	(25,584)	0	0	0	0	0	0	0	(25,584)	36
37	TOTAL Ownership	(67,596)	1,846	7,680	(14,106)	0	0	0	0	0	0	0	(72,176)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(806,155)	(407,292)	62,243	(10,896)	0	0	0	0	0	0	0	(1,162,100)	45

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MNGT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISE	LINCOLNWOOD	MNGT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	EMI	$ 452,500	EMI ENTERPRISES, INC		$	$ (452,500)	1
2	V								2
3	V								3
4	V	17	OFFICER'S SALARY				24,873	24,873	4
5	V	19	ACCOUNTING FEES				320	320	5
6	V	21	OFFICE EXPENSE				13,262	13,262	6
7	V	25	TRANSPORTATION				383	383	7
8	V	26	INSURANCE				297	297	8
9	V	27	EMPLOYEE BENEFITS				4,227	4,227	9
10	V	35	AUTO LEASE				1,846	1,846	10
11	V								11
12	V								12
13	V								13
14	Total			$ 452,500			$ 45,208	$ * (407,292)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 30,000	EKS MANAGEMENT		$	$ (30,000)	15
16	V								16
17	V	6	PAINTERS SALARIES				4,137	4,137	17
18	V	7	SCAVENGER				69	69	18
19	V	17	C F O SALARY				12,655	12,655	19
20	V	19	PROFESSIONAL FEES				15,171	15,171	20
21	V	20	WANT ADS/ BACK GR CKS				1,043	1,043	21
22	V	21	OFFICE EXPENSE				42,670	42,670	22
23	V	23	SEMINARS				66	66	23
24	V	25	TRANSPORTATION				864	864	24
25	V	26	INSURANCE				1,172	1,172	25
26	V	27	EMPLOYEE BENEFITS				6,716	6,716	26
27	V	30	DEPRECIATION				460	460	27
28	V	35	EQUIPMENT RENT				7,220	7,220	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 30,000			$ 92,243	$ * 62,243	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	MEMBER	ADMIN.	40.00	SEE ATTACHED			MNMT FEE	$ 24,873	17-8	1
2											2
3	PHILIP ESFORMES	MEMBER	ADMIN.	40.00	SEE ATTACHED			MNMT FEE	80,000	17-8	3
4											4
5	ARUM WEINFELD		CFO	3.00					12,655	17-8	5
6											6
7											7
8	MICHAEL ROSEN	ADMINISTRATOR		3.00				SALARY	158,684	17-1	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 276,212		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 25,584	IME REALTY		$	$ (25,584)	15
16	V								16
17	V								17
18	V	5	UTILITIES				937	937	18
19	V	6	REPAIRS / MAINTENANCE				1,497	1,497	19
20	V	19	PROFEESIONAL FEES				398	398	20
21	V	21	OFFICE EXPENSE				189	189	21
22	V	26	INSURANCE				189	189	22
23	V	30	DEPRECIATION				2,521	2,521	23
24	V	32	INTEREST				3,887	3,887	24
25	V	33	R/E TAX				4,834	4,834	25
26	V	35	STORAGE FEES				236	236	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 25,584			$ 14,688	$ * (10,896)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARY	PATIENT DAYS	884,739	14	$ 185,000	$ 185,000	118,953	$ 24,873	1
2	19	ACCOUNTING FEES	PATIENT DAYS	884,739	14	2,381		118,953	320	2
3	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	98,637	76,255	118,953	13,262	3
4	25	TRANSPORTATION	PATIENT DAYS	884,739	14	2,845		118,953	383	4
5	26	INSURANCE	PATIENT DAYS	884,739	14	2,209		118,953	297	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	31,442		118,953	4,227	6
7	35	AUTO LEASE	PATIENT DAYS	884,739	14	13,730		118,953	1,846	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 336,244	$ 261,255		$ 45,208	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARY	PATIENT DAYS	884,739	14	$ 30,769	$ 30,769	118,953	$ 4,137	1
2	7	SCAVENGER	PATIENT DAYS	884,739	14	510		118,953	69	2
3	17	C F O SALARY	PATIENT DAYS	884,739	14	94,128	94,128	118,953	12,655	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	884,739	14	112,835	83,281	118,953	15,171	4
5	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	884,739	14	7,759		118,953	1,043	5
6	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	317,364	228,335	118,953	42,670	6
7	23	SEMINARS	PATIENT DAYS	884,739	14	490		118,953	66	7
8	25	TRANSPORTATION	PATIENT DAYS	884,739	14	6,427		118,953	864	8
9	26	INSURANCE	PATIENT DAYS	884,739	14	8,715		118,953	1,172	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	49,951		118,953	6,716	10
11	30	DEPRECIATION	PATIENT DAYS	884,739	14	3,418		118,953	460	11
12	35	EQUIPMENT RENTAL	PATIENT DAYS	884,739	14	53,700		118,953	7,220	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 686,066	$ 436,513		$ 92,243	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	303,433	15	$ 11,111	$	25,584	$ 937	1
2	6	REPAIRS / MAINT	INCOME	303,433	15	17,749		25,584	1,497	2
3	19	PROFESSIONAL FEES	INCOME	303,433	15	4,725		25,584	398	3
4	21	OFFICE EXPENSE	INCOME	303,433	15	2,247		25,584	189	4
5	26	INSURANCE	INCOME	303,433	15	2,237		25,584	189	5
6	30	DEPRECIATION	INCOME	303,433	15	29,895		25,584	2,521	6
7	32	INTEREST	INCOME	303,433	15	46,095		25,584	3,887	7
8	33	R/E TAX	INCOME	303,433	15	57,331		25,584	4,834	8
9	35	STORAGE FEES	INCOME	303,433	15	2,800		25,584	236	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,190	$		$ 14,688	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4	RELATED PARTY										3,887	4
5												5
	Working Capital											
6	CIB BANK		X	WORKING CAPITAL	INTEREST	REVOLV					58,041	6
7	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV			REVOLV	PRIME +	19,276	7
8			X	INSURANCE FINANCING							620	8
9	TOTAL Facility Related						$	$			$ 81,824	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 81,824	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 332,172	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 335,896	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,724	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 335,896	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 339,620	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001	83,725	11
2002	335,896	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESIDENTIAL PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045526

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-31-108-044-0000	NURSING HOME	$ 335,895.62	$ 335,895.62
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 335,895.62	$ 335,895.62

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,056 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 7+BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 3,900
2. Number of Years Over Which it is Being Amortized: 5 YRS
3. Current Period Amortization: 780
4. Dates Incurred: 10/01/01

Nature of Costs: ORGANIZATION/LEGAL
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7	RELATED					2,467		2,467			7
8											8
	Improvement Type**										
9	AWNINGS			2001	10,500	382	27.5	382		812	9
10	FENCE			2001	2,100	140	15	140		298	10
11	ELEVATOR			2001	18,340	667	27.5	667		1,417	11
12	ALARM			2001	5,686	207	27.5	207		440	12
13	WINDOWS			2001	4,149	151	27.5	151		321	13
14	BOILER			2001	3,000	109	27.5	109		14	14
15	FURNISHINGWALLPAPER & BORDERS			2001	12,953	2,154	5	2,591	437	9,158	15
16	KITCHEN SINK & DRAIN			2001	2,525	92	27.5	92		195	16
17	DOORS			2001	15,100	549	27.5	549		1,156	17
18	ELEVATOR			2002	222,811	8,102	27.5	8,102		16,204	18
19	FENCE			2002	3,100	207	15	207		311	19
20	DOORS & LOCKS			2002	21,741	791	27.5	791		1,483	20
21	SHOWER ROOMS			2002	4,669	170	27.5	170		220	21
22	ALARM AND SPRINKLER			2002	11,881	432	27.5	432		557	22
23	EJECTOR & SEWEGE PUMP			2002	14,604	531	27.5	531		686	23
24	ROOF DRAIN			2002	3,100	113	27.5	113		174	24
25	FURNISHING - CARPETS AND DRAPERIES			2002	91,494	20,495	5	18,299	(2,196)	27,448	25
26	ELEVATIR			2003	110,562	3,183	27.5	3,183		3,183	26
27	PARKING LOT			2003	64,182	2,140	15	2,140		2,140	27
28	FIRE ALARM SYSTEM			2003	25,000	492	27.5	492		492	28
29	ROOF			2003	26,500	442	27.5	442		442	29
30	EXTERIOR WALL			2003	9,796	134	27.5	134		134	30
31	SINKS			2003	3,146	62	27.5	62		62	31
32	BUILT IN WARDROBE			2003	19,398	206	27.5	206		206	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 706,337	$ 44,418		$ 42,659	$ (1,759)	$ 67,553	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 480,138	$ 88,887	$ 48,014	$ (40,873)	10 YRS	$ 96,288	71
72	Current Year Purchases	49,131	27,421	2,457	(24,964)	10 YRS	2,457	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		514	514		10 YRS		74
75	TOTALS	$ 529,269	$ 116,822	$ 50,985	$ (65,837)		$ 98,745	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,235,606	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 161,240	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 93,644	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (67,596)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 166,298	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WEDGEWOOD NURSING PAVILION REALTY, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions		328	10/01/01	1,555,650	6		4
5								5
6								6
7	TOTAL		328		$ 1,555,650 **			7

10. Effective dates of current rental agreement:
Beginning 10/01/01
Ending 09/30/08

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$ 1,555,650
13.	/2005	$ 1,555,650
14.	/2006	$ 1,555,650

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 18,642 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINTENANCE	2001 CHEVY EXP VAN	$ 730.00	$ 6,573	17
18	MAINTENANCE	2003 FORD ECO WAGON	746.00	3,623	18
19	ADMINISTRATOR	2002 BMW M3 CONV.	#######	14,334	19
20	DON	2001 INFINITI I-30	519.00	6,253	20
21	TOTAL		$ #######	$ 30,783	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 252,927	$		$ 252,927	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			58,142			58,142	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39.8	hrs			262,994			262,994	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				333,612		333,612	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Supplies, lab	39-8				839	46,101		46,940	13
14	TOTAL			$		$ 574,902	$ 379,713		$ 954,615	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 375,115	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,161,399		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	150,483		6
7	Other Prepaid Expenses	7,400		7
8	Accounts Receivable (owners or related parties)	10,000		8
9	Other(specify): R.E. ESCROW	333,999		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,038,396	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	706,337		15
16	Equipment, at Historical Cost	529,269		16
17	Accumulated Depreciation (book methods)	(468,104)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	3,900		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,755)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Option Dep	250,000		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,019,647	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,058,043	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 290,599	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	268,601		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,197		31
32	Accrued Real Estate Taxes(Sch.IX-B)	335,896		32
33	Accrued Interest Payable	1,476		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 932,769	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO MEMBER	314,500		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 314,500	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,247,269	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,810,774	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,058,043	$	48

*(See instructions.)

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,884,242	1
2	Restatements (describe):		2
3	ROUNDING	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,884,248	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,904,526	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(978,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 926,526	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,810,774	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,125,040	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,125,040	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	65,817	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 65,817	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR EXPENSE	(2,821)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (2,821)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,188,036	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,009,180	31
32	Health Care	4,066,320	32
33	General Administration	2,857,663	33
	B. Capital Expense		
34	Ownership	2,207,255	34
	C. Ancillary Expense		
35	Special Cost Centers	954,615	35
36	Provider Participation Fee	179,580	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,274,613	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,913,423	41
42	**Income Taxes**	(8,897)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,904,526	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,419	2,586	$ 129,832	$ 50.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,788	5,910	133,613	22.61	3
4	Licensed Practical Nurses	74,569	77,291	1,554,528	20.11	4
5	Nurse Aides & Orderlies	159,869	167,044	1,288,039	7.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,484	13,545	133,424	9.85	8
9	Activity Director					9
10	Activity Assistants	21,612	22,595	160,444	7.10	10
11	Social Service Workers	13,907	14,771	175,897	11.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,092	40,607	313,708	7.73	15
16	Dishwashers					16
17	Maintenance Workers	8,476	8,984	106,538	11.86	17
18	Housekeepers	43,260	45,105	322,018	7.14	18
19	Laundry	15,777	16,684	117,132	7.02	19
20	Administrator	3,007	3,218	177,714	55.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,088	23,958	257,418	10.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,985	5,107	49,043	9.60	31
32	Other Health C: MDS, nrsg clerical	10,394	10,733	205,913	19.19	32
33	Other(specify) Security	20,858	21,101	152,998	7.25	33
34	TOTAL (lines 1 - 33)	458,585	479,239	$ 5,278,259 *	$ 11.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 16,123	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	12,972	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		24,000	10a-3	42
43	Speech Therapy Consultant	F	510	10a-3	43
44	Activity Consultant	E	3,360	11-3	44
45	Social Service Consultant	E	4,374	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 67,339		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	261	$ 11,234	10-3	50
51	Licensed Practical Nurses	247	6,409	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	508	$ 17,643		53

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL ROSEN	ADMIN	3	$ 158,684
MARK GREENBERG	ASST ADMIN	0	19,030
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 177,714

B. Administrative - Other

Description	Amount
EMI ENTERPRPISES	$ 452,500
PHILIP ESFORMES, INC	452,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 905,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		116,550
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 116,550

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 156,753
Unemployment Compensation Insurance		58,641
FICA Taxes		393,914
Employee Health Insurance		139,898
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		10,062
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		36,482
CHICAGO HEAD TAX		12,972
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,856
Health Care Worker Background Check	2,050
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,680
TRUST/FRANCHISE/CONTRIB/ETC	4,705
LICENSES & PERMITS	3,062
DUES & SUBSCRIPTIONS	13,174
MGMT CO ALLOCATION	1,043
TRUST/FRANCHISE/CONTRIB/ETC	(4,705)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,680)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,185

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	2,425
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,425

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	2002	$ 10,449	3 YRS	$	$	$ 1,742	$ 3,483	$ 3,483	$ 1,741	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 10,449		$	$	$ 1,742	$ 3,483	$ 3,483	$ 1,741	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $17,712**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,837** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **179,580**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees